REGISTRATION FORM
PLEASE PRINT CLEARLY

PLANTATION GYNECOLOGIC ASSOCIATES LLC
FEMCARE ASSOCIATES LLC

Section I: **PATIENT INFORMATION** **Date**________________

Name: ______________________ Social Security #: ______________ Date of Birth: ______________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner

Address: ______________________City:______________State:_____Zip:_________Apt#: _________

Home Ph. (______) ____________ Work Ph. (_____) ____________Ext:_________ Cell Ph. (______) ____________

Patient Employer: ______________________________ Occupation: ______________________

Spouse Name: ________________________ DOB: ____________ Phone #: ________________

Spouse Employer: ______________________________ Occupation: ______________________

Whom may we thank for referring you? ____

Person to contact in case of emergency: ____________________________ Phone: ________________

If patient is a minor: Parent/Guardian name: ________________ DOB: __________ Ph. #: ______________

Patient Email Address: ____

Primary Language Spoken: ______________________ Do you have a living will? ☐ Yes ☐ No

Section II **POLICY HOLDER INFORMATION**

Are you the primary policy holder of your insurance? ☐ Yes ☐ No
If you checked no, please fill out the information below:

Primary policy holder name: ______________________ Relationship to you: ☐ Self ☐ Spouse ☐ Parent ☐ Partner

DOB: ______________________________ Social Sec. No.: ____________________________

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR, NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES AND OTHERS PAY A PERCENTAGE OF THE CHARGE. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTABLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID BY YOUR INSURANCE COMPANY. **IN ORDER TO CONTROL BILLING COSTS, IT IS THE POLICY OF PLANTATION GYNECOLOGIC ASSOCIATES, LLC. THAT CHARGES FOR OFFICE VISITS BE PAID BY THE CONCLUSION OF EACH VISIT.** PLEASE READ AND SIGN BELOW: I ACCEPT FINANCIAL RESPONSIBILITY FOR CHARGES INCURRED ON MY BEHALF INCLUDING COSTS OF COLLECTIONS (IF APPLICABLE) IN THE EVENT THAT INSURANCE FILED FOR SURGERY OR OTHER SERVICES RENDERED TO ME. I HERBY AUTHORIZE PLANTATION GYNECOLOGIC ASSOCIATES, LLC. TO RELEASE INFORMATION TO MY INSURANCE COMPANY AND ASSIGN BENEFITS DIRECTLY TO PLANTATION GYNECOLOGIC ASSOCIATES, LLC. SHOULD I HAVE A REMAINING BALANCE.

Patient Signature: ________________________________ **Today's Date**: __________